

# ICEMA



Paramedic

Training Program  
Approval Packet



## ICEMA CHECKLIST

### PROCEDURE FOR PARAMEDIC TRAINING PROGRAM APPROVAL

| <i>Materials to Submit with the<br/>Program Approval Application Form</i> |   | <i>Title 22 Authority<br/>Reference No.</i> | <i>Page<br/>No.</i> | <i>FOR<br/>ICEMA<br/>USE<br/>ONLY</i> |
|---|---|---|---------------------|---------------------------------------|
| 1.  | Statement of eligibility for EMT-P Training Program Approval  | 100148 (i)                                  |                     |                                       |
| 2.  | Written request for EMT-P Training Program Approval   | 100153 (a)                                  |                     |                                       |
| 3.  | Proof of Accreditation by the Commission on Accreditation of Allied Health Education Programs (CAAHEP)  | 100153 (a)                                  |                     |                                       |
| 4.  | Statement verifying that the course content is equivalent to the U. S. Department of Transportation (DOT) Emergency Medical Technician-Paramedic National Standard Curriculum HS 808 862 March 1999 | 100153 (b) (1)                              |                     |                                       |
| 5.  | An outline of course objectives   | 100153 (b) (2)                              |                     |                                       |
| 6.  | Performance objectives for each skill   | 100153 (b) (3)                              |                     |                                       |
| 7.  | Program Medical Director Information Form   | 100149 (a)<br>100153 (b) (4)                |                     |                                       |
| 8.  | Program Course Director Information Form  | 100149 (b)<br>100153 (b) (4)                |                     |                                       |
| 9.  | Program Principal Instructor Information Form   | 100149 (c)<br>100153 (b) (4)                |                     |                                       |
| 10.   | Program Teaching Assistant Information Form   | 100149 (d)                                  |                     |                                       |
| 11.   | Location of courses offered and proposed dates  | 100153 (b) (7)                              |                     |                                       |
| 12.   | Statement verifying written agreement(s) with Acute Care Hospital(s) and other clinical setting(s), for student placement of clinical education and training  | 100153 (b) (8)                              |                     |                                       |
| 13.   | Statement verifying written contract(s) or agreement(s) with ambulance agency(ies) for student placement of field internship training   | 100153 (b) (9)                              |                     |                                       |
| 14.   | Final Skills Competency Examination   | 100153 (c) (1)                              |                     |                                       |
| 15.   | Final Written Examination   | 100153 (c) (2)                              |                     |                                       |
| 16.   | Statement verifying adequate facilities, equipment, examination security and student record keeping   | 100153 (c) (3)                              |                     |                                       |

Provide a Table of Contents listing required information with corresponding page numbers.



# INLAND COUNTIES EMERGENCY MEDICAL AGENCY

*Serving San Bernardino, Inyo, and Mono Counties*

**1425 SOUTH "D" STREET**

**SAN BERNARDINO, CA 92415-0060**

**909-388-5823 FAX: 909-388-5825**

## APPLICATION FORM FOR APPROVAL AS AN EMT-P TRAINING PROGRAM

**PROVIDER NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PROGRAM MEDICAL DIRECTOR:** \_\_\_\_\_

**PHONE # (s):** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

**PROGRAM COURSE DIRECTOR:** \_\_\_\_\_

**PHONE # (s):** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

**PRINCIPAL INSTRUCTOR:** \_\_\_\_\_

**PHONE #(s):** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

Attach resumes of the Program Medical Director, Program Course Director and Principal Instructor(s) that demonstrates the individual's experience and qualifications in prehospital care/education. Include copies of all current licenses/certifications/accreditations. Submit the \$1,000.00 application fee. Fees are non-refundable and non-transferable.

*I certify that I have read and understand the local policy for EMT P-Training Program Approval, Title 22, Division 9, Chapter 4 of the California Code of Regulations, effective October 1, 2004 and that I/this agency will comply with all guidelines, policies and procedures described therein. I agree to comply with all audit and review provisions described. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.*

\_\_\_\_\_  
Signed, Program Medical Director

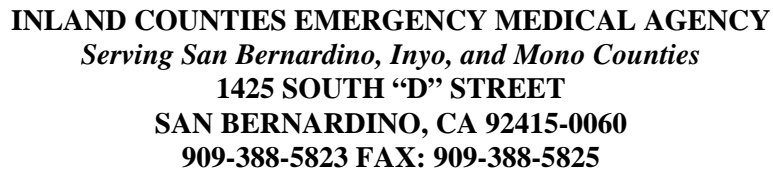
\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed, Program Course Director

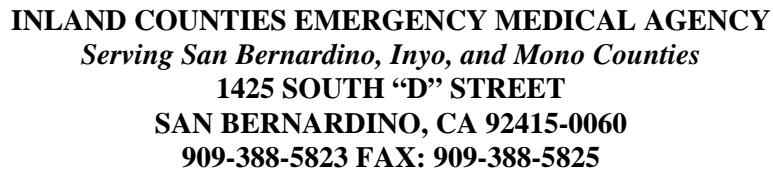
\_\_\_\_\_  
Date

### ***(ICEMA Use Only)***

| Application Recvd Date | Approval Date | Expiration Date | Date Paid/Receipt # |
|------------------------|---------------|-----------------|---------------------|
|                        |               |                 |                     |



Approved By/Date: \_\_\_\_\_



**PROVIDER NAME:** \_\_\_\_\_

**PROGRAM COURSE DIRECTOR:** \_\_\_\_\_

EMAIL: \_\_\_\_\_

FAX: \_\_\_\_\_

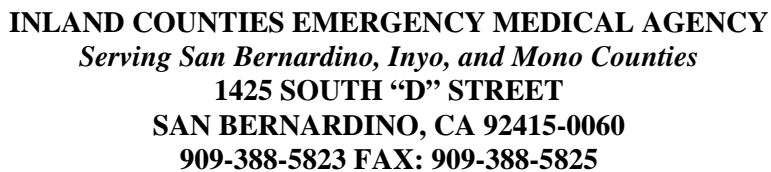
- ☐ Eligibility Status (Reference 100149 (b) )
- ☐ Current Resume (Curriculum Vitae)
- ☐ Copy of Current State of California Licenses (Physician, Physician Assistant, RN or Paramedic)

[illegible]

-----**FOR ICEMA USE ONLY**-----

**Approved:**      ☐ **Yes**                      ☐ **No (Attach explanation on separate sheet)**

Approved By/Date: \_\_\_\_\_



**COMPLETE ONE FORM FOR EACH INSTRUCTOR**

FAX: \_\_\_\_\_

PROVIDE THE FOLLOWING:

- ☐ Eligibility Status (Reference 100149 (c) )
- ☐ Current Resume (Curriculum Vitae)
- ☐ Copy of Current State of California Licenses and/or Certifications/Accreditations

[illegible]

-----FOR ICEMA USE ONLY-----

**Approved:**    ☐ Yes                      ☐ No (Attach explanation on separate sheet)

Approved By/Date: \_\_\_\_\_



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**EMT-P TRAINING PROGRAM TEACHING ASSISTANT INFORMATION**

**PROVIDER NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY/COUNTY/ZIP:** \_\_\_\_\_

**TEACHING ASSISTANT:** \_\_\_\_\_

**PHONE/EMAIL/FAX:** \_\_\_\_\_

**WORK EXPERIENCE RECORD MUST BE ATTACHED (Resume, Curriculum Vitae)**

**\*\*List below those topics to which this Teaching Assistant is assigned and his/her qualifications and experience relative to it:**

| <b>Topic</b> | <b>Qualifications/Experience</b> |
|--------------|----------------------------------|
| _____        | _____                            |
| _____        | _____                            |
| _____        | _____                            |
| _____        | _____                            |
| _____        | _____                            |
| _____        | _____                            |
| _____        | _____                            |
| _____        | _____                            |

Approved By: \_\_\_\_\_

\_\_\_\_\_  
Name (Program Director)

\_\_\_\_\_  
Signature

-----**-FOR ICEMA USE ONLY-**-----

**Approved:**    ☐Yes    ☐No (Attach explanation on separate sheet)

Approved By/Date: \_\_\_\_\_



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### EMT-P TRAINING PROGRAM

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#### NOTIFICATION OF PROPOSED COURSE

**Provider Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Location of Instruction:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Address (if different):** \_\_\_\_\_

**Program Director:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Fee \$** \_\_\_\_\_

\_\_\_\_\_  
**Course Starting Date** **Course Completion Date**

\_\_\_\_\_  
**Date of Written Certifying Exam** **Date of Skills Certifying Exam:**

**Submitted by:** \_\_\_\_\_  
Name (Program Director)

\_\_\_\_\_  
Signature Date

*\*\*This notification should be submitted to ICEMA not less than thirty (30) days before the start of the course. The Program Medical Director, Program Course Director and Program Principal Instructor Information Forms must either be on file at ICEMA or attached to this form prior to the start of the course. All instructors must be approved by ICEMA prior to the start of any course*